IMMEDIATE HEALTH CARE SERVICES REQUEST AND NOTIFICATION TO THE HEALTHY FAMILIES PROGRAM

Instructions: A senior representative from the health plan must fill out and return this form to the Healthy Families Program (HFP) by 5:00 p.m. of the 10th day of the second full calendar month of the infant's life. For example, for an infant born on September 14, the last day for the plan to notify the HFP for purposes of provisional enrollment is November 10. In the situation of an infant born on September 1, the last day to notify the HFP is October 10.

Who is eligible: Only infants born to a woman enrolled in the Access for Infants and Mothers (AIM) Program on or after July 1, 2004 are eligible for streamlined enrollment in the HFP. The health plan representative must notify that the infant is in immediate need of health care services.

What will happen: If the conditions of timely submission and eligibility are met, the HFP will enroll (effective date of birth) the infant in the health plan without receipt of the required HFP premium. If payment is not received by the end of the second full month of enrollment, the infant will be disenrolled from the HFP. Re-enrollment in the HFP will be subject to submitting a new HFP application and meeting HFP eligibility rules.

The health plan should notify the mother of their enrollment request and encourage her to make her required premium as soon as possible to avoid disenrollment.

Any missing information will result in delays in the baby's enrollment. If you need assistance please contact the AIM/HFP Liaison at (916) 673-4603 or e-mail at HFPLanLiaison@MAXIMUS.COM.

Required Information

AIM Application Number: | | | | | | | | | | | |

Mother's First Name: _____ **Middle Int:** ____ **Last Name:** _____

Infant's First Name: _____ **Middle Int:** ____ **Last Name:** _____

Date of Birth: ____ / ____ / ____ **Gender:** **Male** ☐ **Female** ☐

Weight at birth: **Lbs:** _____ **Ounces:** _____

Health Plan Name: _____ **Code:** _____

Primary Care Provider: _____

This form serves as notification that the above named infant is in need of immediate health care services.

Name of Health Plan Representative: _____

Signature of Health Plan Representative: _____

Return this form to:
AIM Program
P. O. Box 15559
Sacramento, California 95852-0559
Attn: AIM Eligibility
FAX: 1-888-889-9238